STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005066	A. BUILDING: _____ B. WING _____	10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of two (2) State complaints. Date of survey: 10-8-2014 Facility Number: 005066 Complaint number: IN00138508 Unsubstantiated; lack of sufficient evidence Complaint number: IN00145401 Unsubstantiated; lack of sufficient evidence Surveyor: Nancy Otten, RN Public Health Nurse Surveyor Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, 15-1.5-10, Utilization Review and Discharge Planning Services, and 15-1.6.2, Emergency Services, Hospital Licensure Rules. QA: claughlin 11/14/14	S 000		